

24 August 2020

The Treasury

Submitted via portal: <https://consult.treasury.gov.au/budget-policy-division/2020-21-pre-budget-submissions/>

To whom it may concern

Re: 2020-21 Pre-Budget Submission

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide this submission in advance of the 2020–21 Australian Government Budget.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks and hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

On 19 December 2019, AHHA made a [pre-budget submission](#) before the Budget was deferred to October. AHHA would like that submission to continue to be recognised as part of the 2020-21 Pre-Budget submission process, and provides the following additional proposals to also be considered:

- Meeting the needs of Young People in Residential Aged Care – a Systems Wrangler training and support program
- Coordinated support to deliver Internet-Parent Child Interaction Therapy (to replace pages 17-18 of the original submission).

The original pre-budget submission is also attached.

If you have any further questions regarding this submission, please do not hesitate to contact us.

Sincerely,



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**Pre-budget 2020-21 Submission to Treasury
24 August 2020**

Meeting the needs of Young People in Residential Aged Care – a Systems Wrangler training and support program

Opportunity

To develop an effective system wrangler workforce, which:

- For individuals, will provide well-designed and coordinated transitions to community from residential aged care and direct from acute settings; sustainability of long-term support arrangements; greater choice and control over services; better skilled workers; and better communication with service providers;
- For services, will provide greater understanding of people's need; improved linkage and communication with other services; improved design of supports; and real-time demand information for housing market and workforce development;
- For Government, will provide a targeted delivery mechanism for the Young People in Residential Aged Care (YPIRAC) strategy; reduced program duplication; improved systemic efficiency; improved data quality; better communication across service programs and jurisdictions.

Context

YPIRAC often require concurrent services from different programs (aged care, health, NDIS and other disability programs, housing, mental health, justice, etc). To deliver concurrent services, a mechanism is needed that enables services to negotiate and collaborate across portfolios and jurisdictions. The Royal Commission into Aged Care Quality and Safety (ACRC) found that a dedicated role (a systems wrangler) bringing together services from different systems around people with complex needs is needed to solve the YPIRAC issue. The ACRC supported the implementation of systems wrangling as this mechanism.

System wranglers have a strong working knowledge of health, aged care and NDIS systems; are a primary point of reference throughout transition for different service programs and YPIRAC; and manage cross program relationships and risks. They build trust and confidence with younger aged care residents/families, and capacity of aged care and health service staff. They provide a time limited service, developing integrated exit plans incorporating NDIS and other supports.

Those currently delivering cross-program service coordination are rare, and have evolved organically, in isolation and without the structures required for sustainability. They have been fundamental in informing the work to date to reconceptualise the service system and define the role and function of the system wrangler.¹

¹ YPINH, Systems Wranglers Roundtable Report, December 2015.



Proposed solution

The important core competencies for an effective system wrangler, as described under the Australian Skills Classification², will be teamwork, problem solving, initiative and innovation, and planning and organisation.

These skills will be complemented by a broad knowledge of the multiple sectors, services and providers and their interconnections and disconnections.

It is anticipated that the wrangler workforce will be drawn from people with knowledge and experience of some but not all sector and system components. Prerequisites would include: a related qualification (health, disability or aged care), the ability to work effectively with different sectors and apply various lenses to complex problems.

A training and support program is proposed that will provide both foundational knowledge development and ongoing support and professional development through a mentoring network to optimise the effectiveness of the wrangler role. The program would be structured to efficiently address the needs of a relatively small but dispersed workforce.

Overview

The program will provide wranglers with strategies and resources that will help them:

- Be innovative, strategic and creative
- Take on new perspectives
- Build on their professional strengths and knowledge of the YPIRAC group and the services and systems they rely on.

On enrolment in the program, participants will be assigned to small groups to work through the modules together, share learnings and expertise, and link with an experienced practitioner to provide support and mentoring.

Online modules

A series of online modules will provide foundational knowledge and increased awareness of system components beyond the usual sphere of practice. Topics will include:

- Understanding the experience of the YPIRAC group
- An overview of the multiple sectors, funding models, and programs
- Principles of negotiation and mediation
- Goal setting; service design, planning and implementation
- Successful transition to home or the community from RAC and/or hospitals.

Facilitated workshops and mentoring

The small groups will also participate in 'live' online workshops and discussion groups where a case-study approach will be used to explore YPIRAC issues, challenges, opportunities and solutions.

The workshops and mentoring will be delivered on an ongoing basis to develop the wrangler network, share learnings and build practice skills and resilience.

² <https://www.nationalskillscommission.gov.au/snapshot-time-australian-labour-market-and-covid-19-report>

Development and delivery:

Key elements of program development and delivery will be:

- **Co-design** using a range of activities and processes to involve the people most likely to be affected by the program, in particular YPIRAC, their families and carers; service providers and those in existing system wrangler roles
- **Online learning design principles** to achieve behaviour change, both in the way wranglers themselves work and the way in which systems engage with wranglers
- **Sound project governance and oversight** through a steering committee with members comprising younger people living in aged care, online education expert, PHN representative, industry reps (aged care, health, disability: advocacy)
- **Strong partnerships**, working with service providers and stakeholders across the various sectors to promote and achieve uptake and building communities of interest
- **Accountability** through embedded evaluation of the effectiveness of the System Wrangler program, as well as enabling ongoing understanding of the issues faced by YPIRAC in service access.

Costs:

An indicative budget of \$1.641 million over three years is proposed.

		Year 1	Year 2	Year 3	Total
Project Management	Project Manager (Yr 1 0.75 FTE, Yr2-3 0.25 FTE) (inc oncosts)	\$ 120,000	\$ 60,000	\$ 60,000	\$ 240,000
	Co-design engagement	\$ 60,000			\$ 60,000
Online modules	Online portal establishment	\$ 45,000			\$ 45,000
	Annual hosting	\$ 55,000	\$ 55,000	\$ 55,000	\$ 165,000
	Module development	\$ 500,000			\$ 500,000
	Content fees, copyright	\$ 50,000	\$ 20,000	\$ 20,000	\$ 90,000
	Module accreditation, CPD assessment	\$ 15,000			\$ 15,000
Workshops and mentoring	IT Licence fees	\$ 20,000	\$ 20,000	\$ 20,000	\$ 60,000
	Facilitator and mentor fees	\$ 72,000	\$ 72,000	\$ 72,000	\$ 216,000
Program Evaluation		\$ 75,000	\$ 50,000	\$ 125,000	\$ 250,000
Total		\$ 1,012,000	\$ 277,000	\$ 352,000	\$1,641,000

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Pre-budget 2020-21 Submission to Treasury
24 August 2020

Coordinated support to deliver Internet-Parent Child Interaction Therapy

Key recommendations:

- Karitane be resourced to improve access across Australia to Internet-Parent Child Intervention Therapy (I-PCIT), a gold standard telehealth treatment intervention for young children with behavioural and disruptive conduct disorders. Importantly, this service has been impactfully delivered and rapidly scaled during the Parenting in a Pandemic Covid-19
- Resourcing should include support for workforce capacity building, delivering training to develop PCIT clinicians in Child and Adolescent Mental Health Services across Australia.

Opportunity

The Commonwealth to provide coordinated support to Karitane to deliver Parent Child Interaction Therapy (PCIT) via telehealth on a national scale.

Context

While some difficulty adjusting to parenthood is common and normal, severe and persistent problems can develop into chronic mental health concerns for parents and severe behavioural and conduct issues for children. Left untreated, these issues typically persist, and the child is at greater risk of developing severe and chronic behaviour and conduct disorders.^{1,2} A behaviour disorder may be diagnosed when disruptive behaviours are uncommon for a child's age at the time, persist over time, or are severe. Because disruptive behaviour disorders involve acting out and showing unwanted behaviour towards others, they are often called externalizing disorders. This kind of behaviour negatively impacts the child and the people around them. This can manifest as mental illness or social and emotional difficulties, and has been linked with eventual substance misuse and criminal activity.³

Services exist to support parents and young children, but significant access barriers persist and COVID-19 has added additional access issues to traditional face-face clinic interventions. Not all interventions have such a compelling evidence base and demonstrated impact as PCIT. Regional families travel thousands of kilometres for specialist services. All families can struggle to take time off work and access care for siblings. Clinic-based support is not timely, often with long waitlists. New parents are typically young, digitally-savvy and seeking support services online. Existing online services are patchy, yet the technology required is improving daily.

¹ Campbell SB 1995, Behavior Problems in Preschool Children: A Review of Recent Research. The Journal of Child Psychology and Psychiatry, vol. 36, no. 1, pp. 113-149.

² Hemphill SA 1996, Characteristics of Conduct—Disordered Children and Their Families: A Review. Australian Psychologist, vol. 31, no. 2, pp. 109-118.

³ Broidy LM et al 2003, Developmental trajectories of childhood disruptive behaviors and adolescent delinquency: A six-site, cross-national study. Developmental Psychology, vol. 39, no. 2, pp. 222-245.

Proposed solution

Karitane has led the delivery of high-quality perinatal mental health services in New South Wales, including the Internet-Parent Child Interaction Therapy (I-PCIT) intervention model, creating more accessible services, regardless of where a family lives, through the Karitane Digital Parenting Hub. This model of care is well aligned with the Australian Government Digital Health Strategy, Covid-19 response planning and the emerging National Children's Mental Health Strategy.

Karitane is internationally recognised as Australia's centre for excellence with measurable impactful outcomes in the delivery of the gold standard Parent Child Interaction Therapy (PCIT) for children aged 18 months to 5 years. This is clinically proven to:

- treat severe persistent behaviour and conduct disorders in young children;
- improve parenting effectiveness, family functioning and social cohesion; and
- reduce symptoms of perinatal depression and anxiety, affecting at least 20% of new parents.

Early intervention services are shown to deliver sustained ROI for individuals over a lifetime, with strong evidence for substantial benefits to wider society as a whole. PCIT is shown to have a clinically measurable positive effect six years after therapy is completed. These services also benefit families and society. PCIT has demonstrated returns over US\$15 per dollar invested.⁴ Compelling evidence is also outlined in two significant reports in 2019: the NSW First 2000 Days Framework; and the CoLab report on How Australia can invest in children and return more.^{5,6}

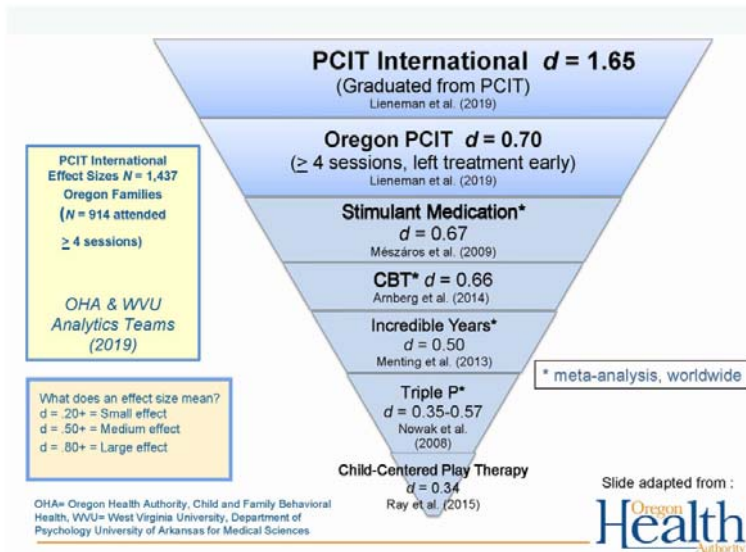
As part of a new, innovative suite of offerings, Karitane has successfully implemented Internet-Parent Child Interaction Therapy (I-PCIT) in regional NSW for NSW Health over the last two years, demonstrating effectiveness and accessibility of this therapy. This has expanded considerably as an effective, scalable telehealth service delivered during the COVID-19 pandemic with increased demand and waitlists up from 6 to 16 weeks for parents seeking support for children with significant behavioural issues.

Delivering I-PCIT nationally will significantly improve health and mental health service delivery to families with young children across Australia, more important now than ever with the mental health impacts of Covid-19, and provide tangible social and economic benefits across our communities. It will also increase interstate partnerships between parenting support service providers to encourage better integrated care, promote and advocate for better digital care options for young families, and foster development of innovative evidence-based parenting support programs.

⁴ Washington State Institute for Public Policy. 2018. Parent-Child Interaction Therapy (PCIT) for families in the child welfare system. Available at <https://www.wsipp.wa.gov/BenefitCost/Program/77>

⁵ NSW Ministry of Health. 2019. The first 200 days – conception to age 5 framework. NSW Ministry of Health, Sydney. Available at https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_008.pdf

⁶ Teager W, Fox F and Stafford N. 2019. How Australia can invest early and return more: A new look at the \$15b cost and opportunity. Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia. Available at <https://colab.telethonkids.org.au/siteassets/media-docs---colab/coli/full-report-how-australia-can-invest-in-children-and-return-more---final.pdf>



The above figure demonstrates the magnitude of PCIT outcomes which have been found to be superior to other well-known evidence-based programs including Triple P, the Incredible Years, and Child-Centered Play Therapy. Specifically, effect size calculations allow researchers to ascertain the relative impact of interventions by examining the strength of the relationship between outcomes. A small effect is generally classified as ≥ 0.2 , while a medium effect is ≥ 0.5 , and a large effect is ≥ 0.8 .

Karitane's Chief Executive leads the Australasian Association of Parent & Children's Health (AAPCH) and will foster strong interstate referral pathways to support an integrated continuum of care for families. This will link up services nationally in a way that has not been available before in child and family health.

Access to parenting support should not depend on what state a family lives in. A strong referral network and nationally consistent online service delivery will ensure continuity of care and high quality support nationally.

Cost

Approximately \$8 million over four years.



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2020–21 PRE-BUDGET

Submission to Treasury

19 December 2019



OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective
Accessible
Equitable
Sustainable
Outcomes-focused.

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide this submission in advance of the 2020–21 Commonwealth Government Budget.

AHHA is Australia’s national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks and hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

The 2020-21 Budget will be the first passed down since the May 2019 re-election of the Morrison Government. This provides the opportunity to take decisive steps to reform the Australian healthcare system and to provide additional resources in areas of known need.

All states and territories have now signed-on to the Heads of Agreement for the 2020-25 National Health Agreement and meaningful action must be taken around the various areas for reform listed in this agreement.

There have also been substantial and damning reports released into mental healthcare and aged care services in Australia that clearly signal the urgency for reform. The Government should act ahead of the finalisation of these two inquiry processes due to the compelling nature of the problems identified. The final reports will differ in some respects, but the substantive problems that need to be addressed will not.

AHHA understands that ongoing renewal and reform are features of the Australian health system, driven both by budget pressures and a desire for system improvement, and the need for better patient outcomes. Australians place high value on universal access to a quality health system. To meet this expectation, the 2020–21 Budget must ensure there is continued support for an effective, accessible, equitable and sustainable healthcare system focused on quality outcomes.

The current fee for service funding model in Australia places the focus on throughput of patients rather than sustained, improved health outcomes being achieved. A fundamental area for reform of our healthcare system, as flagged in clause 7 of the Heads of Agreement, is to move from volume-based care to a system of value-based healthcare, where patients are at the centre and the outcomes achieved in the provision of this healthcare are the focus.

This submission outlines a number of areas of reform to the healthcare system that are achievable with leadership by the Commonwealth Government, working in cooperation with state and territory governments, Primary Health Networks and other groups. The way our healthcare system is organised needs to be adapted to more effectively deliver healthcare services to improve patient care and to achieve system efficiencies. This submission provides a number of practical and necessary recommendations on how this can be achieved with a broad focus on outcomes, coordination of care and specific areas requiring health policy leadership.



RECOMMENDATIONS

<p>Moving from Volume to Value (pages 5 - 6)</p> <ul style="list-style-type: none"> • Value-based healthcare training, supporting resources, mentoring and communities of practice, tailored to an Australian audience and context, for Australian health services. • Develop a web-based clearinghouse of quality-assessed evidence on value-based healthcare • Resourcing to implement the National Health Information Strategy, enabling use of patient-reported outcome and experience measures for patient care, and performance benchmarking.
<p>Aboriginal and Torres Strait Islander Health (pages 7 - 8)</p> <ul style="list-style-type: none"> • Develop a cohort of Aboriginal and Torres Strait Islander people as health coaches to be employed in very remote communities, to support primary healthcare efforts. • Invest in design and development of appropriate training to support micro-credentialing within the Aboriginal and Torres Strait Islander Health Workers training pathway.
<p>Advance Care Planning and Palliative Care (pages 9 - 10)</p> <ul style="list-style-type: none"> • A nationally consistent legislative framework is developed to support end-of-life decision-making and advance care planning. • Introduce MBS items to better support the involvement of general practitioners, allied health professionals, nurse practitioners and primary care nurses in advance care planning and palliative care. • Introduce MBS items to support the involvement of palliative care specialists in case-conferencing and family meetings. • Develop a national minimum data set for non-admitted patients' palliative care.
<p>Aged Care (pages 11 - 12)</p> <ul style="list-style-type: none"> • Provide extra funding for home care packages. Phase out supply caps and invest in increased workforce capacity within the sector. Invest in data development to measure and monitor unmet need and equity of access to aged care services. • Invest in improved care and accommodation options for younger people with complex care needs, including those in residential aged care and via appropriate support through the NDIS. • Initiate immediate steps to enable meaningful system reform of the aged care sector, as proposed through the Interim Report from the Royal Commission into Aged Care.
<p>Alcohol and Other Drugs (pages 13 - 14)</p> <ul style="list-style-type: none"> • Improve the size and focus of investment in the alcohol and other drugs treatment sector by updating and implementing the Drug and Alcohol Services Planning Model (DASPM). • Invest in service and workforce capability through the establishment and funding of an Alcohol and Other Drugs Treatment Sector Capability Fund. • Improve coordination and governance across the alcohol and other drugs treatment sector.



<p>Allied Health Services in Rural and Remote Communities (pages 15 - 16)</p> <ul style="list-style-type: none"> • Develop an allied health workforce dataset to support evaluation of changes in models of care. • Resourcing to implement an Allied Health Rural Generalist Pathway, including investment in an accreditation program.
<p>Children’s Mental Health (pages 17-18)</p> <ul style="list-style-type: none"> • Karitane be resourced to improve access across Australia to Internet-Parent Child Intervention Therapy (I-PCIT), a gold standard telehealth treatment intervention for young children with behavioural and disruptive conduct disorders. • Resourcing should include support for workforce capacity building, delivering training to develop PCIT clinicians in Child and Adolescent Mental Health Services across Australia.
<p>Medicines (pages 19-20)</p> <ul style="list-style-type: none"> • For states and territories participating in the Public Hospital Pharmaceutical Reforms, implement a policy change to allow the Closing the Gap PBS Co-Payment measure to be applied when medicines are dispensed from a public hospital. • The Australian Commission on Safety and Quality in Health Care be funded to develop and publish National Quality Use of Medicines Indicators to inform investment in the Quality Use of Medicines Grants Program and activity of NPS MedicineWise.
<p>Mental Health (pages 21 - 22)</p> <ul style="list-style-type: none"> • Enable mental health policy reforms identified by the Productivity Commission in areas including workforce, MBS, data collection, and local commissioning and funding structures. • Implement arrangements to support joint funding and planning at the local level for mental healthcare services between Primary Health Networks, Local Hospital Networks and community service providers. • Expand MBS support for telehealth, video-conferencing and other innovative online services for mental health treatment.



Oral Health (pages 23 - 24)

- \$500 million per year for the National Partnership Agreement on Public Dental Services for Adults with state and territory funding levels maintained, and the term of the agreement extended to 31 December 2024.
- Funding allocations that reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with higher needs.
- Require states and territories to increase access to fluoridated water supplies. Fluoride varnish programs should be provided to high risk children, particularly in non-fluoridated areas.
- \$50 million over the next three years to fund water fluoridation infrastructure.
- Actively promote the Child Dental Benefits Schedule to eligible families.
- Treble the number of scholarships for Aboriginal and Torres Strait Islander dental students.
- Capital investment for every dental school to have a teaching clinic in a local AMS.
- Incorporate oral health assessments into health assessment frameworks, particularly those at risk, for example children and older people.
- Appoint an Australian Chief Dental Officer to provide national coordination of oral health policy

Preventive Healthcare (pages 25 - 26)

- Increase preventive health funding to 2.3% of recurrent expenditure on health.
- Commit resources to support the forthcoming National Preventive Health Strategy to address risk factors and determinants including overweight and obesity, alcohol misuse and abuse, tobacco consumption, inequality and immunisation; and associated data development.
- Support Primary Health Networks and Local Hospital Networks to develop shared regional needs assessments, priority setting and funding for regionally targeted preventive health initiatives that respond to local community needs.
- Invest in evidenced-based strategies to discourage the consumption of sugar-sweetened beverages, including introduction of a 20% ad valorem sugar-sweetened beverages tax, with revenue hypothecated for preventive health measures.
- Implement a five-year transition period to shift from voluntary to mandatory implementation of the Health Star Food Rating System.

Private Healthcare (page 27 - 28)

- Funding for the Productivity Commission to conduct an independent comprehensive review of government support for private healthcare in Australia.
- This review should assess the value to the Australia community, and the impact on the public health system, of government support of private healthcare through subsidies and other policies.
- This review should assess the most effective ways that the Australian Government can support private healthcare, such that it complements and does not compromise the integrity of Australia's universal healthcare system, Medicare.



MOVING FROM VOLUME TO VALUE

Key recommendations:

- Value-based healthcare training, supporting resources, mentoring and communities of practice, tailored to an Australian audience and context, for Australian health services.
- Develop, promote and maintain an Australian-tailored web-based clearinghouse of quality-assessed evidence on value-based healthcare to support the transition to this new model for funding and delivering better health outcomes.
- Resourcing to implement the National Health Information Strategy, with the appropriate governance, infrastructure and reporting in place to enable the use of patient-reported outcome and experience measures in patient care, in addition to performance benchmarking at the level of the individual clinician, service, state/territory and nationally.

Opportunity: Consistent with COAG health reforms agreed by all Commonwealth, state and territory governments, AHHA proposes the development of a suite of resources to support the Commonwealth’s stewardship of value-based healthcare, including support for health services to make the transition from current service delivery models to models focused on value in healthcare.

Context: AHHA has led a substantial body of work on how to transition Australia’s health sector towards value-based, outcomes-focused and patient-centred healthcare.^{1,2}

Section 7c of the February 2018 Council of Australian Governments Heads of Agreement on public hospital funding and national health reform includes paying for value and outcomes as part of new long-term system-wide reforms agreed for further development by the COAG Health Council. State and territory health departments and agencies are currently undertaking work on value-based care, and some individual service providers are also leading programs. However, these programs are often impeded by a lack of evidence in the Australian context, and risk being siloed, small scale pilots rather than leading to broad system change—restricting systematic translation and adoption of effective strategies.

RESOURCES AND TRAINING

Proposal: Value-based healthcare training, supporting resources, mentoring and communities of practice, tailored to an Australian audience and context, focused on four domains:

1. **Enabling value in healthcare**—the change management process to align national and institutional goals, enable clinician leadership and engage broader stakeholder buy-in.
2. **Measuring outcomes and costs**—collecting and using data to drive change.
3. **Implementing integrated and patient-centred care**—redesigning care models for value, including journey mapping to ensure a shared understanding of patient experience.
4. **Enabling outcomes-based payment approaches**—redesigning funding and payment models for value.

¹ Australian Healthcare and Hospitals Association 2017, *Healthy people, healthy systems: Blueprint for a Post-2020 National Health Agreement with Case Study Exemplars*, Australian Healthcare and Hospitals Association, viewed 6 December 2019, www.ahha.asn.au/blueprint.

² Establishment of the Australian Centre for Value-Based Health Care including training and publication of research www.valuebasedcareaustralia.com.au



Feedback from Australian participants in international-led training programs is that Australian case studies and methodology need to be developed.³

Commonwealth investment—through the Department of Health and AHHA—could fund the development and roll-out of Australian-tailored value-based healthcare implementation supporting resources and training of executives, policymakers and clinicians.

Pilot programs could inform development of strategies for implementing and adopting value-based and outcomes-focused approaches.

Cost: \$1.0 million annually

WEB-BASED CLEARINGHOUSE

Proposal: Web-based sharing of quality assessed evidence, for example, case studies, academic and grey literature—specific to and supporting the Australian context—would bring information together in a usable way to support the transition to value-based healthcare.

Feedback from AHHA members and stakeholders is that there is an absence of evidence to inform system design, and that investment in building a repository of evidence, including quality-assessed grey literature, would assist in scaling up small scale trials and projects. The Commonwealth Department of Health and AHHA would then be able to provide healthcare leaders with a wide range of resources to support the transition to value-based care.

Cost: \$1.0 million set up with annual \$300,000 maintenance

MEASURING OUTCOMES THAT MATTER TO PATIENTS

Proposal: National health data must prioritise the collection of patient-recorded outcome and experience measures (PROMs and PREMs) to enable a patient-centred, outcomes-focused and value-based approach to the delivery of healthcare.

Commonwealth leadership and investment in implementing the collection of such data will enable the appropriate governance, infrastructure and reporting to be in place, which can then be used to support patient care and performance benchmarking at the level of the individual clinician, service, state/territory and nationally. This will require further development of the Australian Health Performance Framework to include outcome measures, building on work already being done in some jurisdictions and facilitating benchmarking with international data including datasets being developed by the OECD. Further details are available in a report published by the AHHA's Australian Centre for Value-Based Health Care.⁴

³ 42nd International Hospital Federation World Hospital Congress Redefining Healthcare Workshop—Implementing Value-based Health Care, facilitated by Professor Elizabeth Teisberg, Brisbane, 9 October 2018.

⁴ Raymond, K. Reforming for value: opportunities for outcome-focused national health policy. Viewed 13 December 2019, https://valuebasedcareaustralia.com.au/wp-content/uploads/2019/10/deeble_issues_brief_no.33_reforming_for_value_opportunities_for_outcome-focused_national_health_policy.pdf



ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Key recommendations:

- Develop a cohort of Aboriginal and Torres Strait Islander people as health coaches to be employed in very remote communities, to support primary healthcare efforts.
- Invest in design and development of appropriate training to support micro-credentialing within the Aboriginal and Torres Strait Islander Health Workers training pathway.

Opportunity: The intended outcome is to improve the health of people in very remote Aboriginal and Torres Strait Islander communities, with additional benefits including community development, local employment and skills training.

Proposal: The project will use locally recruited, trained and managed Aboriginal or Torres Strait Islander people as health coaches to intensify primary healthcare efforts in very remote communities, targeting the health needs of approximately 20,000 people. An initial group of 40 health coaches will be employed within their local community health centre, Aboriginal Medical Service (AMS) or Aboriginal Community Controlled Health Organisation (ACCHO) following training, using a micro-credentialing approach, within the Aboriginal and Torres Strait Islander Health Workers training pathway. They will intensively support patient compliance with primary healthcare treatments/recommendations.

Who does it involve? Development and delivery of the training pathways, supervision, mentorship and management of the Aboriginal or Torres Strait Islander health coaches, including program evaluation, will require a co-design approach involving a training package development organisation, Primary Health Networks (PHNs), the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA), health researchers, relevant NACCHO affiliates, vocational education and training providers, and state and territory health departments. At a minimum, a partnership consisting of NATSIHWA, AHHA, a PHN and relevant NACCHO affiliate, will be required. AHHA will provide advocacy and coordination for the partnership, in addition to project evaluation.

Is there policy alignment? A health coaching approach is strongly aligned with the principles and priorities of regional and national policies, including the National Aboriginal and Torres Strait Islander Health Implementation Plan, National Safety and Quality Health Service Standard 2 (Partnering with Consumers) and the National Strategic Framework for Chronic Conditions.

Are there additional benefits? Additional project benefits include entry into a recognised training pathway, entry-level employment opportunities in local communities where unemployment is high, improved sustainability by using local people who are more likely to stay in their community, as well as utilisation of their superior language skills, local knowledge and community relationships.



What is the evidence? Intensive primary healthcare support has demonstrated success in reducing the biomedical risk factors for cardiovascular disease, high blood pressure and abnormal blood lipids, in remote Aboriginal communities. In addition, basic primary healthcare delivered by health workers produces good clinical outcomes for patients with diabetes. Basic primary healthcare can also reduce risk factors for rheumatic heart disease and support the provision of mental health services.

Cost: \$6.0 million for training and employment of up to 40 Aboriginal and Torres Strait Islander health coaches for one year (\$150,000 each). Thereafter approximately \$100,000 employment and management costs per coach per annum.



ADVANCE CARE PLANNING AND PALLIATIVE CARE

Key recommendations:

- A nationally consistent legislative framework is developed to support end-of-life decision-making and advance care planning.
- Integration of advance care planning documents in My Health Record with primary care, hospital, community and aged care electronic health records is enhanced.
- There is system-wide transformation of palliative care services and models of care to better respond to end-of-life needs and to meet increasing demand. These changes will require a coordinated and integrated approach across primary, community, aged care, specialist and hospital care.
- Medicare Benefit Schedule items are introduced to support the involvement of general practitioners, allied health professionals, nurse practitioners and primary care nurses in advance care planning and palliative care.
- Medicare Benefit Schedule items are introduced to support the involvement of palliative care specialists in case-conferencing and family meetings.
- A national minimum data set for non-admitted patients' palliative care is developed.

Opportunity: To improve advance care planning and palliative care services for all Australians.

Context: Australians are living longer, with the number of deaths in Australia set to double over the next 25 years⁵. Palliative care aims to improve the quality of life of people with life-threatening illness, their families and carers. This involves management of disease symptoms, psychosocial and spiritual aspects of care, as well as effective coordination of services across the health system.

Health and aged care services have inadequate capacity to provide consistent and coordinated care for current and future palliative care needs.

AHHA recognises that balancing healthcare expectations within the resource-constrained health system to provide satisfactory palliative care is challenging. While hospitalisation at end-of-life is common, with improved advance care planning it is possible to firstly improve care by reducing hospitalisations and unwanted and often invasive life prolonging treatment, and secondly to reduce their associated costs by providing access to less acute inpatient palliative or hospice care⁶.

Proposals: AHHA supports the Senate Community Affairs Reference Committee recommendation to harmonise laws across all jurisdictions on advance care planning documents and substitute decision-makers⁷. This will support a nationally consistent approach protecting clinicians from medico-legal risk and providing a decision-making framework to support patients in accessing the care they wish to receive.

My Health Record accepts uploads of advance care planning documents. However, access to these documents should be enhanced, with greater linkage and alerts to the existence of these documents in primary care, hospital, community and aged care electronic health records. This will facilitate continuity and coordination of care, improve clinician awareness and assist in providing care that

⁵ Swerissen H and Duckett S 2014, *Dying well*, Grattan Institute, Melbourne.

⁶ McCarthy IM, Robinson C, Huq S, Philastre M and Fine RL 2015, 'Cost savings from palliative care teams and guidance for a financially viable palliative care program', *Health Services Research*, vol. 50, no. 1, pp. 217–236.

⁷ Community Affairs Reference Committee (CARC) 2012, *Palliative care in Australia*, Community Affairs References Committee, The Senate, Commonwealth of Australia, Canberra.



aligns with Advance Care Directives. Additionally, such systems could potentially prompt discussion and documentation of advance care planning at key times in the patient journey, including:

- At agreed milestones (such as 75+ health assessments);
- During chronic disease planning and with the development of multiple comorbidities; and
- At onset of dementia.

Review of the Medicare Benefit Schedule items for the provision of advance care planning and palliative care are necessary. This should include establishment of items to support involvement of general practitioners, allied health professionals, nurse practitioners and primary care nurses in advance care planning and palliative care. Additional items should also be established to support the involvement of palliative care specialists in case conferencing and family meetings.

Data on palliative care are not comprehensive, particularly across the community-based sector, making it very difficult to measure the number of patients accessing services and the total government expenditure across states and territories⁸. Standardised high-quality data supports outcomes-focused care, recognising community need and supporting allocation of resources. It is recommended that funding is allocated to engage with Primary Health Networks, and states and territories to develop a palliative care data collection framework. This will provide a minimum data set for non-admitted patients' palliative care to support increased access to high quality regionally appropriate care.

New aged care accreditation and quality standards for residential aged care, home care and flexible care under development must include advance care planning and palliative care. These standards will support access to care, quality of care and outcomes for consumers accessing aged care services.

Better advance care planning and palliative care coordination have the potential to improve patient outcomes while also providing savings to the health system. With an ageing population, this proposal is a sensible approach towards the dignified treatment of older Australians, those living with chronic diseases, and for the health and aged care systems.

⁸ Productivity Commission 2017, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services – Inquiry report*, no. 85, Productivity Commission, Canberra.



AGED CARE

Key recommendations:

- The Commonwealth Government must take immediate action to reduce waiting times by providing extra funding for people approved for home care packages. This will require the Commonwealth to phase out supply caps and invest in increased workforce capacity within the sector, in addition to investing in the development of better data to measure and monitor unmet need and to ensure equity of access to aged care services.
- Invest in improved care and accommodation options for younger people with complex care needs, including those in residential aged care and via appropriate support through the NDIS.
- Initiate immediate steps to enable meaningful system reform of the aged care sector, as proposed through the Interim Report from the Royal Commission into Aged Care.

Opportunity: Every older person should be able to live well, with dignity and independence, as part of their community and in a place of their choosing, with a choice of appropriate and affordable support and care services when they need them. Aged care services must be of high-quality and responsive to the diversity of need, with independent monitoring, transparent public reporting and accountability upheld.

Context: The Royal Commission into Aged Care Quality and Safety Interim Report handed down in October 2019 has described a neglectful system that is cruel and discriminatory⁹. It concluded that funding from the Australian Government should be forthcoming to ensure the timely delivery of home-based aged care services. The Department of Health indicated that it would take \$2–2.5 billion per annum to provide access to all people on the waiting list at the level of care they needed.

Access to home care packages is slow, with more people waiting for packages at their approved level, than are currently receiving packages¹⁰. Previous reviews have recommended phasing out supply caps for aged care places. For these reforms to be considered and sustainably implemented, investment is needed to increase workforce capacity within the sector, in addition to better data to measure and monitor unmet need and equity of access.

The Report also highlights that there are 6,000 Australians aged under 65 years living in residential aged care¹¹. This is inappropriate—residential aged care is not suitable for younger people. Young people living in residential aged care typically have a complex illness or disability, high care needs and high acuity. Young people living in residential aged care also have social and cultural needs, which often differ from older residential aged care service users.

No younger Australians should be entering residential aged care, instead they should receive care in more appropriate settings.

⁹ Commonwealth Royal Commission into Aged Care Quality and Safety 2019, *Royal Commission into Aged Care Quality and Safety Interim Report: Neglect*, Volume 1, viewed 18 November 2019, <https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-1.pdf>.

¹⁰ Commonwealth Department of Health 2019, *Home Care Packages Program Data Report 4th Quarter 2018-19*, viewed 18 November 2019, https://www.gen-agedcaredata.gov.au/www.aihwgen/media/Home_care_report/HCP-Data-Report-2017%E2%80%932nd-Qtr.pdf.

¹¹ Commonwealth Royal Commission into Aged Care Quality and Safety 2019, *Royal Commission into Aged Care Quality and Safety Interim Report: Neglect*, Volume 1, viewed 18 November 2019, <https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-1.pdf>.



Proposal: The various documented shortcomings within the aged care sector in Australia have been known for considerable time. The Interim Report of the Royal Commission into Aged Care Quality and Safety states the need for fundamental reform and redesign of the aged care system. This report also foreshadows that the Final Report to be provided to the Commonwealth Government in November 2020 will recommend a whole-of-system reform and redesign.

The Commonwealth should therefore initiate immediate steps to reduce waiting times for people with approved home care packages, invest in increased workforce capacity, ensure that younger Australians with high care needs are appropriately supported by the NDIS and enable broader meaningful system reform of the aged care sector to occur. This should include:

- Primary care, palliative care, pain management and chronic disease management being aligned with the quality of care available to other Australians.
- Access to clinically appropriate, high-quality and safe primary care and specialist care being available to people receiving aged care services when required.
- Changes to Medicare Benefits Scheme items for services provided by primary healthcare providers to allow flexible access including non face-to-face consultations.
- State and territory public dental services should be adequately resourced and required within the new National Partnership Agreement on Adult Public Dental Services to deliver oral health care for eligible aged care residents.
- The Aged Care Quality Standards should be amended to explicitly require services to demonstrate staff capacity (number, skill and type), processes and sound clinical governance.
- Residential aged care services must enable timely access to health professionals able to prescribe and dispense appropriate medicines.
- All residential aged care services should be able to administer medicines for their residents 24 hours per day and seven days a week.
- A national set of quality indicators for aged care services should be developed, measured, monitored and publicly reported by all aged care service providers.
- Monitoring, evaluation and public reporting of residential aged care service performance is needed around:
 - Access, quality, safety and outcomes for primary care services and frequently used healthcare services in residential aged care facilities;
 - Preventable hospitalisations; and
 - Clinical governance in relation to healthcare provided in residential aged care facilities.
- Funding Instruments for identifying care needs and allocating resources must be evidence-based, responsive and flexible to support the provision of appropriate and timely care; and should support moving towards a value-based approach to funding aged care
- Aged care providers must be supported to introduce standardised tracking of evidence-based health outcomes and cost of care.
- Arms-length assessment processes for service providers to ensure independence when determining eligibility and classification for aged care.
- Information systems that are fit-for-purpose, focussed on health outcomes and facilitate achieving value in aged care and transparency of performance around care quality and safety.
- National standards for information systems to ensure evidence-based performance and outcomes data are accurately captured.
- Aged care service providers required under the terms of funding arrangements to provide data for public reporting of quality and safety.
- Information systems that embed interoperability requirements to enhance communication between health and disability services and providers. Interoperability with My Health Record must be prioritised.



ALCOHOL AND OTHER DRUGS

Key recommendations:

- Improve the size and focus of investment in the alcohol and other drugs treatment sector by updating and implementing the Drug and Alcohol Services Planning Model (DASPM).
- Invest in service and workforce capability through the establishment and funding of an Alcohol and Other Drugs Treatment Sector Capability Fund.
- Improve coordination and governance across the alcohol and other drugs treatment sector.

AHHA has joined with a coalition of health organisations led by St Vincent’s Health Australia to provide a Pre-Budget Submission in support of improved coordination across all levels of government to enhance the integration and delivery of alcohol and other drugs treatment services in Australia.

To address the unmet demand in Australia’s treatment services, this submission presents three priority areas for structural reform of Australia’s alcohol and other drugs treatment sector. The submission proposes three key recommendations for the Australian Government.

Opportunity: Alcohol and other drugs (AOD) treatment works when people can access the right kind of care at the right time and in the right place, with clinical and social support tailored to what is best for the individual. AOD treatment provides benefits in a number of ways: individuals benefit from the improved health outcomes and increased quality of life associated with treatment; health services benefit from reduced demand for acute and emergency services when those with substance use disorders receive appropriate treatment; and society benefits from increased investment in AOD treatment, not only through avoiding costly care associated with the complications of untreated substance use disorders, but also by avoiding disruption to employment, family life, and the broader community. It has been estimated that for every \$1 spent on treatment services, there is a \$7 return to the community.¹²

Context: In Australia, 952 publicly-funded Alcohol and Other Drugs (AOD) treatment services provided almost 210,000 treatment episodes to nearly 130,000 clients in 2017-18.¹³ Of this, the most common drugs which led to clients seeking treatment were alcohol (35%), amphetamines (27%), cannabis (22%) and heroin (6%). Despite the health, social and economic benefits of AOD treatment services to individuals and communities, there is a considerable unmet demand across the country. It is estimated that up to 500,000 people cannot get the help they need from AOD treatment services. These services are either not available or the waiting lists are too long. The situation is most severe in regional and rural Australia.

Improve the Size and Focus of Investment in the Alcohol and Other Drugs Treatment Sector

Proposed work: Implement the Drug and Alcohol Services Planning Model (DASPM) by initially forming a working group and establish a process to update the model, and then implementing it to guide investment in the AOD treatment sector.

¹² Ritter A, Berends L, Chalmers J, Hull P, Lancaster K and Gomez M 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW. Available at <https://ndarc.med.unsw.edu.au/resource/new-horizons-review-alcohol-and-other-drug-treatment-services-australia>.

¹³ *ibid.*



The AOD treatment sector is one of the last sectors not to utilise a national evidence-informed planning framework to guide and plan public investment. We call on the Australian Government, working together with state and territory governments, to fund and embed a nationally consistent planning model for the Australian AOD treatment sector. This can be achieved by ensuring the DASPM remains epidemiologically and clinically relevant to inform joint planning for investment in services. The updated and revised DASPM can then be used nationally to predict demand and plan investment.

Invest in Service and Workforce Capability

Proposed work: Establish and fund an Alcohol and Other Drugs Treatment Sector Capability Fund, working closely with state and territory governments.

The Capability Fund would provide professional advice as well as financial grants to AOD treatment organisations. Funding would be provided for evidence-based service improvement and evaluation, effective specialist AOD treatment workforce, and capital works to improve the physical infrastructure of services. The Capability Fund would enable rapid improvement in AOD treatment service quality and accessibility, including the retention and development of a capable and effective workforce. This will mean that across the country the service system can immediately start to generate better outcomes from AOD treatment for hundreds of thousands of Australians and their families.

Improve Coordination and Governance Across the Alcohol and Other Drugs Treatment Sector

Proposed work: The Australian, state and territory governments should work together on a national strategy for the AOD treatment sector. This strategy should:

- Advise on a comprehensive and integrated system of clinical and social services for individuals and families experiencing alcohol and other drug-related problems;
- Implement initiatives to address stigma and discrimination against people with alcohol and drug-related problems, and alcohol and drug treatment service staff;
- Promote better coordination between different levels of government, their agencies, and communities in the development of the workforce, including a peer workforce and delivery of treatment services;
- Contribute to the development of a culture of continuous improvement in Australia's AOD treatment sector and enhance the accountability and transparency of treatment services through the provision of independent reports and advice, as well as the development of evidence-based guidelines for treatment;
- Ensure consumer voices are represented and that policy and service provision takes into account consumer experience and needs;
- Identify unmet needs and makes recommendations about legislation and funding to address those needs, as well as to ensure there is ongoing investment in continuity of care to address relapse and long-term needs of individuals and their families; and
- Allow for the coordination and provision of data to high level forums such as the Ministerial Forum for Drugs and Alcohol so support for the workforce at state and territory levels is evidence-based and directed at the needs of each jurisdiction.

Cost: Across the three proposed areas, \$1.141 billion per annum, with the Commonwealth funding approximately 40% of these outlays and the balance provided by state and territory governments.¹⁴

¹⁴ These estimates are based on Ritter *et al* 2014 (*op cit*).



ALLIED HEALTH SERVICES IN RURAL AND REMOTE COMMUNITIES

Key recommendations:

- The Australian Institute for Health and Welfare (AIHW) should be resourced to develop a dataset on the allied health workforce to support the pursuit and evaluation of outcomes-focused and value-based changes in scopes of practice and models of care.
- Support is needed for implementing and embedding the Allied Health Rural Generalist Pathway across the three components of the Pathway, including investment in an accreditation program.

Opportunity: The Commonwealth to provide coordinated support to facilitate access to allied health services to meet the need of rural communities, quality of services and the improved distribution of the rural allied health workforce.

Context: With recognition of the work of the National Rural Health Commissioner in developing recommendations to Government by 31 December 2019 on effective and efficient strategies, AHHA reiterates its recommendations to the Commissioner that governance is critical to enabling this to be carried out most effectively. A broad range of functions are required which vary in the extent to which:

- There should be an expectation of Commonwealth support
- Existing entities hold the expertise and experience required
- Efficiencies can be gained through existing entities and structures
- The influence of vested interests will be an impediment to reform and need to be managed
- Community need must be addressed as the primary purpose through governance structures.

AHHA cautions against proposing a single prescriptive solution to address allied health rural needs when it is known that the strengths and needs of each rural community is unique and changing. Actions taken will be determined not only by evidence and the needs of a particular population, but also by the pattern of services and infrastructure that has evolved in each community.

Investment in allied health services in rural and remote communities should recognise the roles of existing entities in identifying and addressing community needs, and integrate with and build on, not replicate or conflict with, these responsibilities and accountabilities.

Investment should reflect the agreement expressed in the February 2018 Council of Australian Governments Heads of Agreement for reforms relating to better coordinated care through joint planning and funding at a local level, in particular by Local Hospital Networks (or equivalent) and Primary Health Networks, including co-design with consumers.



DATA ON ALLIED HEALTH WORKFORCE

Proposal: A dataset on the allied health workforce must go beyond the numbers and distribution of the workforce as it currently exists, and support the pursuit and evaluation of outcomes-focused and value-based changes in scopes of practice and models of care.

The AIHW would be best placed to lead work on the development of a data set to understand the rural allied health workforce. This should align and build on the work already done (eg the Allied Health National Best Practice Data Sets relating to public hospital services, and the National Health Workforce Data Set: allied health practitioners) and work being undertaken to develop a National Primary Health Care Data Asset.

RURAL AND REGIONAL ACCESS TO SERVICES

Proposed work: Support is needed for implementing and embedding the Allied Health Rural Generalist (AHRG) Pathway across the three components of the Pathway. These are:

1. Service models that address the challenges of providing the broad range of healthcare needs of rural and remote communities.
2. Workforce and employment structures that support the development of rural generalist practice capabilities through supervision and education.
3. An education program tailored to the needs of rural generalist allied health practitioners, building on work led by AHHA on behalf of Queensland Health, and overseen by a multi-jurisdictional partnership, to develop an accreditation system to support the AHRG Pathway.

Sustainability in implementing and embedding the Pathway would be achieved by:

- Building on existing structures to support funders, commissioners and service providers to implement cross-sector Primary Health Network/Local Hospital Network partnerships. Access to allied health services will be enabled by responding to local needs assessments through: regional governance models (clinical and business); supervisory, managerial and education support; and strategies for pooling funds.
- Quality assurance of education programs through an accreditation system to support the AHRG pathway. Detailed planning work on an accreditation model has been undertaken by AHHA on behalf of SARRAH and Queensland Health; see https://www.health.qld.gov.au/data/assets/pdf_file/0028/720496/ahha-accreditation.pdf This is an important component of the overarching AHRG pathway, including the Allied Health Rural Generalist Workforce and Education Scheme announced by Minister Coulton on 22 November 2019. Without investment in a formal accreditation program which brings together education organisations, professional groups and health service providers, the current funded arrangements are a continuation of previous training and business models which have failed to demonstrate positive outcomes.
- Subsidies for workforce training provided only until student numbers are sufficient for a self-sustaining system.
- Recognising the needs of individuals working across sectors and disciplines in rural and remote areas; and expanding the Pathway to support all allied health professions and support workers as well as to the disability and aged care sectors.

Cost: \$20.0 million over four years



CHILDREN'S MENTAL HEALTH

Key recommendations:

- Karitane be resourced to improve access across Australia to Internet-Parent Child Intervention Therapy (I-PCIT), a gold standard telehealth treatment intervention for young children with behavioural and disruptive conduct disorders.
- Resourcing should include support for workforce capacity building, delivering training to develop PCIT clinicians in Child and Adolescent Mental Health Services across Australia.

Opportunity: The Commonwealth to provide coordinated support to Karitane to deliver Parent Child Interaction Therapy (PCIT) via telehealth on a national scale.

Context: While some difficulty adjusting to parenthood is common and normal, severe and persistent problems can develop into chronic mental health concerns for parents and severe behavioural and conduct issues for children. Left untreated, these issues typically persist, and the child is at greater risk of developing severe and chronic behaviour and conduct disorders.^{15,16} A behaviour disorder may be diagnosed when disruptive behaviours are uncommon for a child's age at the time, persist over time, or are severe. Because disruptive behaviour disorders involve acting out and showing unwanted behaviour towards others, they are often called [externalizing disorders](#). This kind of behaviour negatively impacts the child and the people around them. This can manifest as mental illness or social and emotional difficulties, and has been linked with eventual substance misuse and criminal activity.¹⁷

Services exist to support parents and young children, but significant access barriers persist and not all interventions have such a compelling evidence base and demonstrated impact as PCIT. Regional families travel thousands of kilometres for specialist services. All families can struggle to take time off work and access care for siblings. Clinic-based support is not timely, often with long waitlists. New parents are typically young, digitally-savvy and seeking support services online. Existing online services are patchy, yet the technology required is improving daily. Karitane has led the delivery of high-quality perinatal mental health services in New South Wales, including the Internet-Parent Child Interaction Therapy (I-PCIT) intervention model, creating more accessible services, regardless of where a family lives, through the Karitane Digital Parenting Hub. This model of care is well aligned with the Australian Government Digital Health Strategy and the emerging National Children's Mental Health Strategy.

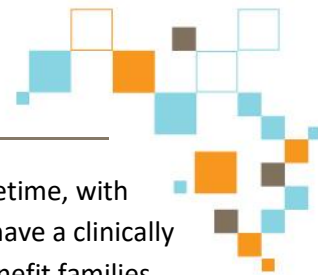
Karitane is internationally recognised as Australia's centre for excellence with measurable impactful outcomes in the delivery of the gold standard Parent Child Interaction Therapy (PCIT) for children aged 18 months to 5 years. This is clinically proven to:

- treat severe persistent behaviour and conduct disorders in young children;
- improve parenting effectiveness, family functioning and social cohesion; and
- reduce symptoms of perinatal depression and anxiety, affecting at least 20% of new parents.

¹⁵ Campbell SB 1995, Behavior Problems in Preschool Children: A Review of Recent Research. *The Journal of Child Psychology and Psychiatry*, vol. 36, no. 1, pp. 113-149.

¹⁶ Hemphill SA 1996, Characteristics of Conduct—Disordered Children and Their Families: A Review. *Australian Psychologist*, vol. 31, no. 2, pp. 109-118.

¹⁷ Broidy LM *et al* 2003, Developmental trajectories of childhood disruptive behaviors and adolescent delinquency: A six-site, cross-national study. *Developmental Psychology*, vol. 39, no. 2, pp. 222-245.



Early intervention services are shown to deliver sustained ROI for individuals over a lifetime, with strong evidence for substantial benefits to wider society as a whole. PCIT is shown to have a clinically measurable positive effect six years after therapy is completed. These services also benefit families and society. PCIT has demonstrated returns over US\$15 per dollar invested.¹⁸ Compelling evidence is also outlined in two significant reports in 2019: the NSW First 2000 Days Framework; and the CoLab report on How Australia can invest in children and return more.^{19,20}

As part of a new, innovative suite of offerings, Karitane has successfully implemented Internet-Parent Child Interaction Therapy (I-PCIT) in regional NSW for NSW Health over the last two years, demonstrating effectiveness and accessibility of this therapy.

Delivering I-PCIT nationally will significantly improve health and mental health service delivery to families with young children across Australia, providing tangible social and economic benefits across our communities. It will also increase interstate partnerships between parenting support service providers to encourage better integrated care, promote and advocate for better digital care options for young families, and foster development of innovative evidence-based parenting support programs.

Karitane's Chief Executive leads the Australasian Association of Parent & Children's Health (AAPCH) and will foster strong interstate referral pathways to support an integrated continuum of care for families. This will link up services nationally in a way that hasn't been available before in child and family health.

Access to parenting support should not depend on what state a family lives in. A strong referral network and nationally consistent online service delivery will ensure continuity of care and high quality support nationally.

Cost: \$8 million over four years

¹⁸ Washington State Institute for Public Policy 2018, Parent-Child Interaction Therapy (PCIT) for families in the child welfare system. Available at <https://www.wsipp.wa.gov/BenefitCost/Program/77>.

¹⁹ NSW Ministry of Health 2019, The first 200 days – conception to age 5 framework. NSW Ministry of Health, Sydney. Available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwiB-tIvr7mAhUj4nMBHa1CAf4QFiABegQIDBAF&url=https%3A%2F%2Fwww1.health.nsw.gov.au%2Fpds%2FActivePDSDocuments%2FFPD2019_008.pdf&usq=AOvVaw1X43gSv2OyA8P7arOkDnE.

²⁰ Teager W, Fox F and Stafford N 2019, How Australia can invest early and return more: A new look at the \$15b cost and opportunity. Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia. Available at <https://colab.telethonkids.org.au/siteassets/media-docs---colab/coli/full-report-how-australia-can-invest-in-children-and-return-more---final.pdf>.



MEDICINES

Key recommendations:

- For states and territories participating in the Public Hospital Pharmaceutical Reforms, immediately implement a policy change to allow the Closing the Gap PBS Co-Payment measure to be applied when medicines are dispensed from a public hospital.
- The Australian Commission on Safety and Quality in Health Care be funded to lead development of National Quality Use of Medicines Indicators for the community. The measurement of these indicators should then be published consistent with the Australian Atlas of Healthcare Variation and be used to inform the investment in the Quality Use of Medicines Grants Program and activity of NPS MedicineWise at the national level, as well as the collaborative activity at the jurisdictional and Primary Health Network (PHN) level.

IMPROVING ACCESS TO MEDICINES

Opportunity: To improve access to medicines for Aboriginal and Torres Strait Islander people when discharged from hospital.

Context: Aboriginal and Torres Strait Islander people are less likely than non-Indigenous people to access medicines in the community. Average PBS expenditure per person for Aboriginal and Torres Strait Islander Australians was estimated to be 33% of the amount spent for non-Indigenous Australians in 2013–14, despite higher rates of chronic disease and hospitalisation.²¹

Patients not taking their medicines after discharge from hospital is a major problem resulting in poor health, clinical deterioration, re-hospitalisation and death. Acute separations and emergency department attendances present an opportunity to improve access to medicines.

All states and territories, except NSW and ACT, are participating in the Public Hospital Pharmaceutical Reforms that enables hospitals to prescribe and dispense PBS subsidised medicines to outpatients and patients upon discharge. However, the Closing the Gap (CTG) PBS Co-Payment Measure cannot be applied when pharmaceuticals are dispensed from a public hospital.

Proposal: The CTG PBS Co-Payment measure be applied when medicines are dispensed from public hospitals to improve medicines access by Aboriginal and Torres Strait Islander people living with or at risk of chronic disease. This would address a range of barriers to accessing needed medicines faced by patients including out-of-pocket costs, transport to community pharmacies and accessibility of community pharmacies upon returning to their communities.

It should be noted that both the cost of the medicine and the cost of the co-payment relief are already incorporated into the current PBS budget as part of the CTG PBS Co-payment Measure. A policy change would only realign the location of supply of medicines to patient need, and theoretically should not lead to additional PBS medicines being dispensed. Rather, it would address the under-utilisation of current CTG support in the community.

²¹ Australian Health Ministers' Advisory Council (AHMAC) 2017, Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, AHMAC, viewed 29 January 2019
<https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier3/315.html>.



Cost: For states and territories participating in the Public Hospital Pharmaceutical Reforms, a policy change could be implemented immediately without renegotiating agreements. This would involve a re-direction of existing budgeted funds estimated to be \$15.1 million.

If ACT and NSW were also to participate, the re-direction of funds is estimated to be an additional \$6.7 million.

QUALITY USE OF MEDICINES PROGRAM

Opportunity: NPS MedicineWise was established with Australian Government funding in 1998 and ongoing funding has been provided through the Program for the services NPS provides without substantial or independent review.

Context: The Australian Government's Quality Use of Medicines Program is important in the implementation of and support for the National Strategy for Quality Use of Medicines. Investment in the approach to quality use of medicines implementation should be: nationally unified and regionally responsive; evidence informed, and transparently and independently monitored; and provide an integrated experience for consumers and clinicians, with consistent messaging in health and healthcare.

Funding for the Quality Use of Medicines Program should not be given in a manner that creates segregation or duplication of the roles, expertise and scope of existing entities (eg data collection and general practice quality improvement and support by Primary Health Networks, the development, analysis and reporting on data by the Australian Institute of Health and Welfare or activities of the Australian Commission on Safety and Quality in Health Care).

Work commissioned by the Australian Government to NPS MedicineWise should be explicitly and formally integrated and coordinated with the work of other entities funded by governments, leveraging expertise held by other entities and minimising inefficiencies and duplication.

PHNs should be instrumental in the implementation of the Quality Use of Medicines Program to address local needs. Plans for implementation at the regional level should be agreed and monitored with the respective PHN, with a transparent understanding of the resources being allocated by NPS MedicineWise. This would support evaluation of investment and impact at the PHN level.

Proposal: In order to effectively and independently evaluate the value from the investment in the Quality Use of Medicines Grants Program, the Australian Commission on Safety and Quality in Health Care should be funded to lead development of National Quality Use of Medicines Indicators for the community (that is beyond Australian hospitals).

The measurement of these indicators should then be published consistent with the Australian Atlas of Healthcare Variation and be used to inform the investment in the Quality Use of Medicines Grants Program and the activities of NPS Medicine Wise at the national level, as well as the collaborative activity at jurisdictional and PHN level.



MENTAL HEALTH

Key recommendations:

- The Commonwealth should take immediate steps to enable system reforms for those suffering from mental ill-health around the identified areas of workforce, MBS, data collection, and local commissioning and funding structures.
- Joint funding and planning at the local level for mental healthcare services should be between Primary Health Networks, Local Hospital Networks and community service providers.
- The Commonwealth should be flexible in the funding of telehealth and other innovative online services for the treatment of mental health including implementing changes to MBS rules so that telehealth can be more widely implemented for mental health treatment.

Opportunity: The Commonwealth has an opportunity to develop a response in anticipation of the recommendations of the Productivity Commission final report on mental health due in May 2020. This should address structural and funding issues identified in the numerous reviews of the mental health system, and implement systematic reform that enable integrated, coordinated, evidence based and patient-centred care to improve the health and welfare of the almost half of all Australians who will experience mental illness in their lifetime.

Context: Mental health services must be consumer focused and based on prevention, early intervention and support for recovery. Greater investment and research in well-planned, evidence-based, cost-effective, community-based mental health services is required. Investment and reform strategies should recognise the roles of existing services capacities at addressing community needs, and integrate and build on these responsibilities and accountabilities to prevent duplication or the creation of sector silos.

Any major funding shift from crisis teams, emergency departments and acute hospital services towards prevention, early intervention and community services, needs to be planned and delivered over time in the context of an integrated service approach to mental health. Funding shifts must ensure continued access to and availability of acute services for those with mental illness.

Evidence shows that Aboriginal and Torres Strait Islander people, younger generations and people living in rural and remote locations experience a higher burden mental ill health. These programs should be designed to improve health in these disproportionately affected communities, and be led by and co-designed with local health services and communities to ensure that they are place-based, needs-specific and culturally appropriate.

The Productivity Commission draft report on mental health identified significant gaps in access to mental health services as a key priority for reform. The Commonwealth should ensure mental health support is accessible to all Australians in a timely manner, specific to the individual's needs and for the duration of their treatment requirements. This should include the provision of treatment and prevention services through telehealth and other innovative online services.

Proposal: While the final report of the Productivity Commission inquiry into mental health will not be provided to the Government until May 2020, the Key Points made in the draft report are mostly already very well known to the Government and clearly signal the need for a profound change in the way mental health services are delivered across the health and social care continuum. As stated in the report, generational change is required in the treatment of those suffering from mental ill-health.



Many of the reforms recommended have been proposed before and are therefore familiar to governments, providers and those harmed by inadequate mental healthcare services.

The Commonwealth should therefore initiate immediate steps to enable meaningful system reform for those suffering from mental ill-health to be commenced around the identified areas of workforce, MBS, data collection, and local commissioning and funding structures.

Primary Health Networks, Local Hospital Networks and community service providers have extensive expertise and capacities in the provision, coordination and delivery of mental health care. These existing skills and knowledge should be capitalised and built upon in the delivery of funding reforms that prioritises the provision of integrated consumer driven holistic care.

A cross-jurisdictional approach to sector reform is consistent with the February 2018 Council of Australian Governments Heads of Agreement on the new national health agreement requiring joint funding and planning at the local level, and better coordinated care across the health sector. It is also noted that the Fifth National Mental Health and Suicide Prevention Plan is premised on PHNs and LHNs implementing integrated planning and service delivery at the regional level. This is also consistent with the Productivity Commission report *Shifting the Dial*²² that called for regional alliances between Local Hospital Networks, Primary Health Networks and others. AHHA made the same recommendation in *Healthy people, healthy systems*²³, our proposal for ten-year health system reform.

The Commonwealth should also be flexible in the funding of telehealth and other innovative online services for the treatment of mental health, including implementing changes to MBS rules so that telehealth can be more widely implemented for mental health treatment. Legitimate concerns about unexpectedly high or inadequately targeted services can be managed through consultation with affected parties and with the use of mandatory sunset clauses on new treatment options that remove the open-ended obligation of funders to new and innovative services.

²² Productivity Commission 2017, *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra.

²³ Australian Healthcare and Hospitals Association (AHHA) 2017, *Health people, healthy systems*. Available at <https://ahha.asn.au/Blueprint>.



ORAL HEALTH

Key recommendations:

- \$500 million per year for the National Partnership Agreement on Public Dental Services for Adults with state and territory funding levels maintained, and the term of the agreement extended to 31 December 2024.
- Funding allocations that reflect the cost of providing care in rural and remote areas, smaller jurisdictions and to groups with higher needs.
- Require states and territories to increase access to fluoridated water supplies. Fluoride varnish programs should be provided to high risk children, particularly in non-fluoridated areas.
- \$50 million over the next three years to fund water fluoridation infrastructure.
- Actively promote the Child Dental Benefits Schedule to eligible families.
- Treble the number of scholarships for Aboriginal and Torres Strait Islander dental students.
- Capital investment for every dental school to have a teaching clinic in a local AMS.
- Incorporate oral health assessments into health assessment frameworks, particularly those at risk, for example children and older people.
- Appoint an Australian Chief Dental Officer to provide national coordination of oral health policy.

Opportunity: Australia’s National Oral Health Plan 2015–2024 outlines a blueprint for united action across jurisdictions and sectors to ensure all Australians have healthy mouths. Translation of the National Oral Health Plan into practice has been slow, and requires all jurisdictions and sectors to work together to maintain and improve the oral health of Australians.

Context: Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. Despite improvements over the last 20–30 years, there is still evidence of poor oral health among Australians²⁴. Oral conditions are the fourth highest reason for potentially preventable hospital admissions with more than 70,000 Australians hospitalised in 2016–17²⁵. Out-of-pocket costs for dental care are also greater than any other major category of health spending.

Inequities in oral health outcomes continue to persist. Aboriginal and Torres Strait Islander people and adults who are socially disadvantaged or on low incomes have more than double the rate of poor oral health than their counterparts. People with additional or specialised healthcare needs and those living in regional and remote areas and residential aged care facilities also have more difficulty accessing oral healthcare. Access to dental practitioners is also a barrier to dental care, particularly for those Australians living in rural and remote Australia. Capital cities have nearly 2.5 times more dental practitioners per person than remote areas²⁶. In small towns this has widened, despite improved national averages, since 1981²⁷.

PUBLIC DENTAL TREATMENT

Proposal: Funding of \$500 million per year is needed for the National Partnership Agreement (NPA) on Public Dental Services (NPAPDS) with state and territory government funding levels maintained to improve access to and affordability of dental care. The term of the agreement should be extended to 31 December 2024 to align with the term of the Child Dental Benefits Schedule (CDBS).

A series of reductions to the funding for both the National Partnership Agreement on Public Dental Services for Adults and the CDBS have occurred since the 2014–15 Budget. While the 2018–19 Mid-Year Economic and Fiscal Outlook provided a one-year extension to the funding of the NPAPDS, this funding

²⁴ Australian Institute of Health and Welfare (AIHW) 2018, Oral health and dental care in Australia.

²⁵ Australian Institute of Health and Welfare (AIHW) 2019, Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18, Cat. No HPF 36, Canberra: AIHW.

²⁶ Australian Institute of Health and Welfare (AIHW) 2016, Oral health and dental care in Australia: key facts and figures 2015, Cat. no. DEN 229. Canberra: AIHW.

²⁷ Bourne K, Nash A, and Houghton and K 2017, Pillars of communities: Service delivery professionals in small Australian towns 1981–2011, The Regional Australia Institute.



ceases on 30 June 2020. The reduction in Federal funding to the states and territories for oral health means that wait times at public dental clinics, which are already running into years, will only get longer and leave more patients at risk of deteriorating health outcomes and in need of costly remedial treatment in public hospitals.

Cost: \$500 million per year.

PREVENTION

Proposal: The Commonwealth should provide national leadership by working with state and territory governments to ensure fluoridation of all reticulated water supplies in Australia.

There is consistent evidence that water fluoridation at current Australian levels is associated with decreased occurrence and severity of tooth decay in children, adolescents and adults²⁸. Nearly 3 million Australians do not have a fluoridated water supply²⁹.

For example, in Queensland more Aboriginal and Torres Strait Islander people live in areas that either did not implement fluoridation or ceased fluoridation after 2012. As a consequence, about 50 per cent of Aboriginal and Torres Strait Islander people in Queensland do not have access to fluoridated water, although the access rate for the total Queensland population is around 76 per cent³⁰.

AHHA supports a linkage between Commonwealth funding of dental services, through the NPA, and the extent of state and territory water fluoridation programs. The Commonwealth should require states and territories to establish and maintain that a minimum 90 per cent of the population has access to fluoridated water.

Cost: \$50 million for capital works to assist with the development of water fluoridation infrastructure.

BARRIERS TO TREATMENT

Proposal: The Commonwealth better promote the CDBS to the families of eligible children. Better reporting and analysis of CDBS data will also provide stronger evidence for the effectiveness of this program, as well as identifying opportunities to target care for vulnerable groups and those living in geographical areas with limited access to dental services.

Out-of-pocket cost to individuals is acknowledged as a major barrier to appropriate and regular dental care. More than 30% report that they avoid or delay visiting a dentist due to cost³¹. Those in lower household income groups had higher rates of avoiding or delaying a visit to a dentist due to cost than those in higher income groups.

DENTAL WORKFORCE

Proposal: Additional Commonwealth support is required to promote the entry of Aboriginal and Torres Strait Islander people into the dental workforce. Capital investment by the Commonwealth is needed for every dental school to have a teaching clinic in a local Aboriginal Medical Services (AMS).

More Aboriginal and Torres Strait Islander dental practitioners are needed. The leading financial support for these students, the Puggy Hunter Memorial Scholarship hasn't been increased in ten years and there are more than twice as many dental applicants than scholarships available.

The ability of non-Indigenous dental practitioners to deliver culturally safe care for Aboriginal and Torres Strait Islander patients depends upon their undergraduate education as well as regulatory requirements through the Australian Health Practitioner Regulatory Agency. However, this is compromised because most dental schools do not have sufficient access to teaching placements with an AMS.

²⁸ NHMRC 2017, Water fluoridation: dental and other human health outcomes, National Health and Medical Research Council, Canberra. Available at <https://nhmrc.gov.au/about-us/publications/water-fluoridation-dental-and-other-human-health-outcomes>.

²⁹ Australian Bureau of Statistics (ABS) 2017, 3101.0 - Australian Demographic Statistics, March 2017, Commonwealth of Australia, Canberra, viewed 25 January 2019.

³⁰ AMA 2019, 2019 AMA Report Card on Indigenous Health, Australian Medical Association, Canberra. Available at https://ama.com.au/system/tdf/documents/2019%20AMA%20Report%20Card%20on%20Indigenous%20Health_0.pdf?file=1&type=node&id=51639.

³¹ Chrisopoulos, S, Harford, JE and Ellershaw, A 2016, Oral health and dental care in Australia: key facts and figures 2015, Australian Institute of Health and Welfare, Canberra.



PREVENTIVE HEALTHCARE

Key recommendations:

- Increase preventive health funding to 2.3% of recurrent expenditure on health.
- Commit resources to support the forthcoming National Preventive Health Strategy to address risk factors and determinants including overweight and obesity, alcohol misuse and abuse, tobacco consumption, inequality and immunisation; and associated data development.
- Support Primary Health Networks and Local Hospital Networks to develop shared regional needs assessments, priority setting and funding for regionally targeted preventive health initiatives that respond to local community needs.
- Invest in evidenced-based strategies to discourage the consumption of sugar-sweetened beverages, including introduction of a 20% ad valorem sugar-sweetened beverages tax, with revenue hypothecated for preventive health measures.
- Implement a five-year transition period to shift from voluntary to mandatory implementation of the Health Star Food Rating System.

Opportunity: To invest in a range of preventive health initiatives to reduce illness, prevent disease and promote wellness.

Context: A person's healthcare should extend beyond immediate presenting concerns to take a broader view of their health and wellbeing. Such an approach requires consideration of physical, mental and social wellbeing, which is influenced by individual factors, lifestyle, environment and cultural influences, socioeconomic conditions and access to quality health care programs and services. This requires a preventive approach to healthcare, supported by targeted investment by government.

Health should be seen as an investment, not just a cost. As reinforced by the Productivity Commission, there is a strong rationale for a greater emphasis on public health and prevention in an integrated system³², with expenditure on such measures contributing to Budget repair by reducing future demand on the health system while simultaneously improving health outcomes and quality of life for all Australians. This is also consistent with Objective 1 of the National Strategic Framework for Chronic Conditions³³, which is 'to focus on prevention for a healthier Australia'.

Australia spends less on public health and prevention than most other OECD countries, ranked fifth lowest in 2016, with 1.9% of recurrent health spending compared with Canada's 6.2% and the United Kingdom's 5.4%³⁴. Since peaking at 2.3% in 2007–08, Australian spending has fallen to 1.6% in 2017–18³⁵.

Proposal: Funding for preventive health should target a return to funding levels commensurate with the expenditure in previous years of around 2.3% of recurrent expenditure on health³⁶ on activities including health promotion, prevention and early intervention.

³² Productivity Commission 2017, *Shifting the Dial: 5 year productivity review*, Productivity Commission, viewed 19/11/2019, <https://www.pc.gov.au/inquiries/completed/productivity-review/report>.

³³ AHMAC 2017, *National Strategic Framework for Chronic Conditions*, Australian Health Ministers' Advisory Council, viewed 19/11/2019, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/nsfcc>.

³⁴ OECD 2019, *OECD.Stat, Health Expenditure and Financing*, Organisation for Economic Co-operation and Development, viewed 19/11/2019, <https://stats.oecd.org/Index.aspx?DataSetCode=SHA#>.

³⁵ AIHW 2019, *Health Expenditure Australia 2017–18 Supplementary Tables Table A9*, Australian Institute of Health and Welfare, viewed 19/11/2019, <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2017-18/data>.

³⁶ AIHW 2019, *Health Expenditure Australia 2017–18 Supplementary Tables Table A9*, Australian Institute of Health and Welfare, viewed 19 Nov 2019, <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2017-18/data>.



Funds dedicated to prevention activities must be based on regional need. A collaborative approach is required between the Commonwealth, state and territory governments to establish consistent governance arrangements between Primary Health Networks and Local Hospital Networks for shared regional needs assessments, priority setting and funding. This will support delivery of preventive healthcare that is coordinated, integrated and responsive to local need.

A strategic approach to delivering preventive health activities focussed on common risk factors and determinants, rather than individual diseases is also required. Strategic priority areas in preventive health should include overweight and obesity, alcohol misuse and abuse, tobacco control, inequality and immunisation.

Obesity is an Australian health priority with 63% of the adult population overweight or obese³⁷. Obesity has high economic and human consequences at an individual and societal level. Australian modelling shows that the direct health costs of obesity in 2011–12 were \$3.8 billion³⁸.

Increased consumption of energy-dense nutrient-poor foods is the predominant cause of obesity, with estimates that sugar-sweetened beverages (SSBs) account for at least one-fifth of weight gain³⁹. Investment is needed in a broad array of evidenced-based strategies to discourage the consumption of SSBs, incrementally reduce overweight and obesity, and improve health outcomes. This approach should include measures to regulate availability, improve labelling, restrict promotion, reduce consumption and increase public awareness of potential harms.

An additional 20% ad valorem tax will reduce rates of type 2 diabetes, heart disease and stroke, with an estimated 1,600 extra people alive after 25 years, providing considerable health system savings and generating an estimated \$400 million in revenue annually⁴⁰. Revenue raised from a SSBs tax should be hypothecated for preventive health measures including approaches to improve diet, increase physical activity, prevent obesity and educate on nutrition.

The Australia and New Zealand Ministerial Forum on Food Regulation met on 15 November 2019 to consider the five-year review of the Health Star Rating system. Ministers committed to various system improvements recommended in the report aiming to enhance alignment of the Health Star Rating with the Australian dietary guidelines and to improve confidence in the system.

While the Forum agreed to setting clear uptake targets for the Health Star Rating via the development of an implementation plan, it did not commit to a process towards mandatory implementation of the Health Star Rating system. In 2017–18 the Health Star Rating system was displayed on 31% of eligible products⁴¹.

For the Health Star Rating to be effective in providing consumers with a direct comparison of individual foods to allow informed food purchasing, comprehensive uptake is necessary on all processed foods and beverages. While the system remains voluntary food manufacturers will continue to selectively display the Health Star Rating system, preventing consumers from making truly informed decisions on their food purchasing.

³⁷ AIHW 2018, Australia's Health 2018, Australian Institute of Health and Welfare, viewed 19 November 2019.

³⁸ PWC 2015, Weighing the cost of obesity: A case for action, viewed 19 November 2019. Available at <https://www.pwc.com.au/pdf/weighing-the-cost-of-obesity-final.pdf>.

³⁹ Woodward-Lopez G, Kao J and Ritchie L 2011, To what extent have sweetened beverages contributed to the obesity epidemic?, *Public Health Nutrition*, vol. 14, no. 3, pp. 499–509.

⁴⁰ Veerman JL, Sacks G, Antonopoulos N and Martin J. 2016, The Impact of a Tax on Sugar-Sweetened Beverages on Health and Health Care Costs: A Modelling Study, *PLoS One*, vol. 11, no. 4, pp. e0151460.

⁴¹ Mpconsulting 2019, Health Star Rating System Five Year Review Report, viewed 19 November 2019. Available at <http://www.healthstarrating.gov.au/internet/healthstarrating/publishing.nsf/Content/formal-review-of-the-system-after-five-years>.



PRIVATE HEALTHCARE

Key recommendations:

- The Productivity Commission should be directed to conduct an independent comprehensive review of government support for private healthcare in Australia.
- This independent review should assess the value to the Australia community, and the impact on the public health system, of government support of private healthcare through subsidies and other policies.
- This review should assess the most effective ways that the Australian Government can support private healthcare, such that it complements and does not compromise the integrity of Australia's universal healthcare system, Medicare.

Opportunity: Private healthcare in Australia is supported by a range of government subsidies and other policies. The value to the Australian community of these supports needs to be assessed to ensure that the most effective and efficient balance between public and private healthcare services is being achieved.

Context: Australia's mixed public-private health system is entrenched. In 2017–18, 68.3% of all health expenditure was funded by Commonwealth, state and territory governments, which includes services provided by both public and private providers.⁴² A wide range of other government policies are also in place that influence the provision of private healthcare including:

- the defining of privately-provided services and products that are funded publicly (eg the Medicare Benefits Schedule item descriptors and subsidies, the Pharmaceutical Benefit Scheme, the Community Pharmacy agreements, the Child Dental Benefits Schedule, requirements for referral to specialists) and through private health insurance (eg the Prostheses List);
- programs affecting safe and quality care (eg limitations on professional scopes of practice, individual professional registration, credentialing requirements, provider accreditation requirements, the Practice Incentive Program in general practice);
- programs affecting access (eg rural incentive programs, pharmacy ownership and location rules, education and clinical training standards and support);
- incentives for private health insurance (eg the Medicare levy surcharge, the private health insurance rebate, lifetime health cover); and
- regulation of products (eg patents, scheduling of medicines, advertising restrictions).

Proposal: There should be an independent comprehensive review by the Productivity Commission of the public policy objectives that are served by Government support of private healthcare and private health insurance. This review should assess the value to the Australia community, and the impact on the public health system, of government support of private healthcare through subsidies and other policies.

⁴² Australian Institute of Health and Welfare 2019. Health expenditure Australia 2017–18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.



Australia will always have a need for the availability and provision of private healthcare. However, the manner in which government should and should not support private healthcare needs to be clearly articulated, including the public benefits any such support provides. The review should assess the most effective ways that the Australian Government can support private healthcare, such that it complements and does not compromise the integrity of Australia’s universal healthcare system, Medicare.

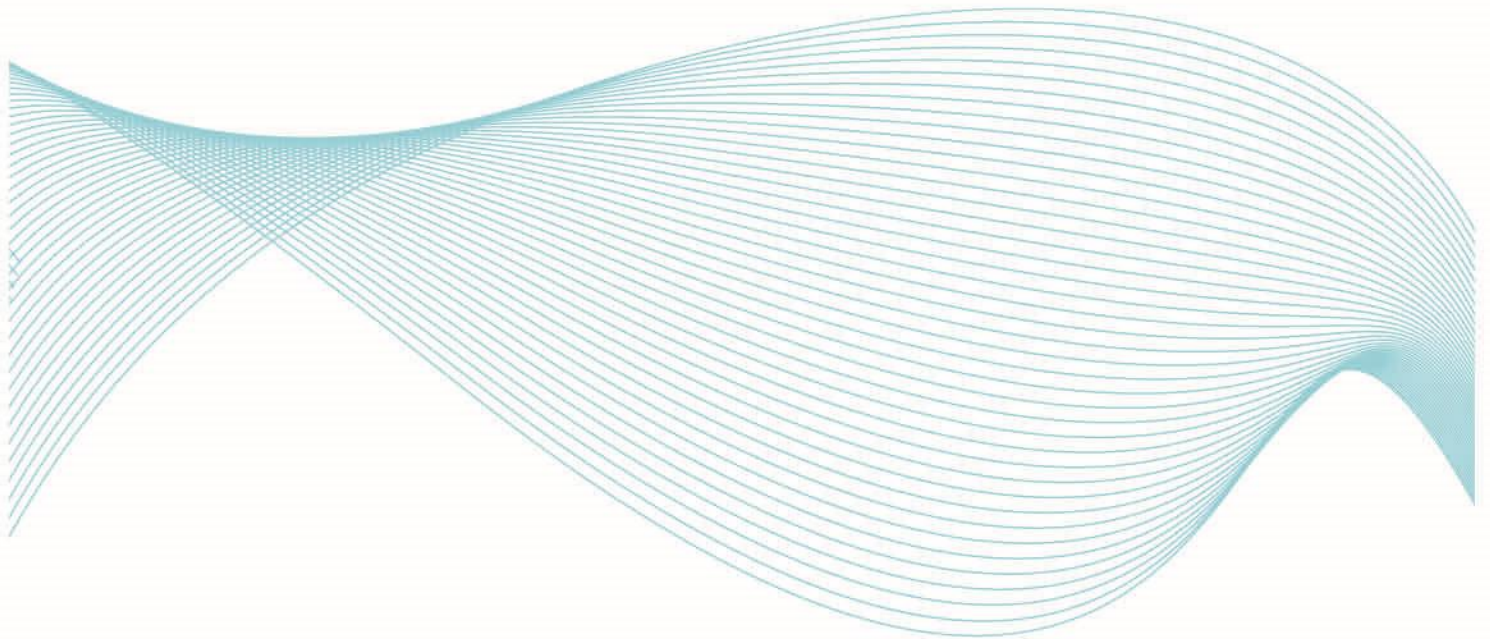


CONCLUSION

This submission outlines a number of areas of reform to the healthcare system that are achievable with appropriate funding and leadership by the Commonwealth Government, working in cooperation with state and territory governments, Primary Health Networks and other groups. This is further supported by the extensive recommendations for health system reform made by AHHA in our *Health people, healthy systems* proposal which outlines changes required to more effectively deliver healthcare services, improve patient care and achieve system efficiencies. The Blueprint is available at www.ahha.asn.au/Blueprint and addresses four domains for health system reform: governance, data, funding and workforce.

Together with this submission, the AHHA Blueprint for health reform provides a number of practical and necessary strategies for reform with a broad focus on outcomes, coordination of care and specific areas requiring health policy leadership. If fully implemented, these proposals present a comprehensive set of meaningful reforms that are based on a staged, strategic and cooperative approach to the reform of the Australian healthcare system.

This submission also calls on the Commonwealth Government to initiate action ahead of the receipt of the final reports on inquiries into mental health services and aged care due to the overwhelming identified need for reform and extra resources, and the well-recognised and documented problems facing these two sectors. The Australian community cannot wait for delayed government action in either of these areas.



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